FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0045930

Facility Name: Tower Hill Healthcare Center

Address: 759 Kane Street (Number) South Elgin (City) 60177 (Zip Code)

County: Kane

Telephone Number: (847) 697-3310 **Fax #** (847) 697-3354

IDPA ID Number: 721525738001

Date of Initial License for Current Owners: 10/25/2002

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	206	Skilled (SNF)	206	75,190	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	206	TOTALS	206	75,190	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	411	91	6,357	6,859	8
9	SNF/PED					9
10	ICF	30,529	10,409	4	40,942	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,940	10,500	6,361	47,801	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.57%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 7/01/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/01/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 6,357

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	268,863	19,528	8,605	296,996		296,996		296,996			1
2	Food Purchase		272,332		272,332		272,332	(6,267)	266,065			2
3	Housekeeping	143,291	90,411		233,702		233,702	384	234,086			3
4	Laundry	92,460	22,604		115,064		115,064		115,064			4
5	Heat and Other Utilities			155,192	155,192		155,192	2,736	157,928			5
6	Maintenance	62,279	114,874	14,377	191,530		191,530	852	192,382			6
7	Other (specify):*											7
8	**TOTAL General Services**	566,893	519,749	178,174	1,264,816		1,264,816	(2,295)	1,262,521			8
	B. Health Care and Programs											
9	Medical Director			26,510	26,510		26,510		26,510			9
10	Nursing and Medical Records	2,052,063	62,551	8,496	2,123,110		2,123,110	(1,174)	2,121,936			10
10a	Therapy			527,172	527,172		527,172		527,172			10a
11	Activities	130,372	13,844		144,216		144,216		144,216			11
12	Social Services	34,227			34,227		34,227		34,227			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,216,662	76,395	562,178	2,855,235		2,855,235	(1,174)	2,854,061			16
	C. General Administration											
17	Administrative	115,426		96,500	211,926		211,926	(5,406)	206,520			17
18	Directors Fees											18
19	Professional Services			40,895	40,895		40,895	2,698	43,593			19
20	Dues, Fees, Subscriptions & Promotion			10,167	10,167		10,167	(539)	9,628			20
21	Clerical & General Office Expense	303,348		62,948	366,296		366,296	85,786	452,082			21
22	Employee Benefits & Payroll Taxe			444,275	444,275		444,275	4,671	448,946			22
23	Inservice Training & Educatior											23
24	Travel and Seminar			4,540	4,540		4,540	51	4,591			24
25	Other Admin. Staff Transportatior			10,871	10,871		10,871	445	11,316			25
26	Insurance-Prop.Liab.Malpractice			19,368	19,368		19,368	1,609	20,977			26
27	Other (specify):* Mgmt alloc. of benefits							20,490	20,490			27
28	**TOTAL General Administration**	418,774		689,564	1,108,338		1,108,338	109,805	1,218,143			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,202,329	596,144	1,429,916	5,228,389		5,228,389	106,336	5,334,725			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tower Hill Healthcare Center #0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			25,808	25,808		25,808	117,399	143,207			30
31	Amortization of Pre-Op. & Org											31
32	Interest			67,053	67,053		67,053	192,815	259,868			32
33	Real Estate Taxes			88,187	88,187		88,187	6,743	94,930			33
34	Rent-Facility & Grounds			420,000	420,000		420,000	(420,000)				34
35	Rent-Equipment & Vehicles			14,640	14,640		14,640	1,605	16,245			35
36	Other (specify):*											36
37	**TOTAL Ownership**			615,688	615,688		615,688	(101,438)	514,250			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		183,800		183,800		183,800		183,800			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,785	112,785		112,785		112,785			42
43	Other (specify):* Nonallowable Cost			112,477	112,477		112,477	(112,477)				43
44	**TOTAL Special Cost Centers**		183,800	225,262	409,062		409,062	(112,477)	296,585			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,202,329	779,944	2,270,866	6,253,139		6,253,139	(107,579)	6,145,560			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,727	30		9
10	Interest and Other Investment Income	(69,679)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(351)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,203)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,875)	43		24
25	Fund Raising, Advertising and Promotional	(34,808)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(26,459)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (181,648)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule	$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	74,069		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 74,069		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,579)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Programs		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider #: 0045930
01/01/2005 to 12/31/2005 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Schedule V Reference
Disallow Lab Expense	(12,674)	43
Disallow X-ray Expense	(11,566)	43
Disallow out of period legal bills	(573)	19
Disallow Chamber of Commerce	(623)	20
Misc income offset	(256)	21
Disallow RT Tax	(767)	43
	(26,459)	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	19	Professional Services	$	Kane Street Associates	100.00%	$ 1,244	$ 1,244	1
2	V	30	Depreciation		Kane Street Associates	100.00%	109,220	109,220	2
3	V	32	Interest		Kane Street Associates	100.00%	260,487	260,487	3
4	V	34	Rent	420,000	Kane Street Associates	100.00%		(420,000)	4
5	V	43	RT Tax		Kane Street Associates	100.00%	767	767	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 420,000			$ 371,718	$ * (48,282)	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider #: 0045930
12/31/2005

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis
Out-of-State:	
St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO

Other Related Business Entities

	S.W. Management Co.	Skokie	Bookkeeping/Management Company
	S&E Medical Supply Co.	Skokie	Medical Supplies
*	SFO Associates	Skokie	Finance Company
**	Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S.W. Mangement Co.	100.00%	$ (34)	$ (34)	15
16	V	3	Housekeeping		S.W. Mangement Co.	100.00%	384	384	16
17	V	5	Heat and Other Utilities		S.W. Mangement Co.	100.00%	2,736	2,736	17
18	V	6	Maintenance		S.W. Mangement Co.	100.00%	852	852	18
19	V	17	Administrative	72,500	S.W. Mangement Co.	100.00%	67,094	(5,406)	19
20	V	19	Professional Services		S.W. Mangement Co.	100.00%	3,846	3,846	20
21	V	20	Dues, Fees, Subs & Promotions		S.W. Mangement Co.	100.00%	84	84	21
22	V	21	Clerical & General Office Expense		S.W. Mangement Co.	100.00%	86,042	86,042	22
23	V	24	Travel and Seminar		S.W. Mangement Co.	100.00%	51	51	23
24	V	25	Other Admin. Staff Transport		S.W. Mangement Co.	100.00%	445	445	24
25	V	26	Insurance-Prop.Liab.Malpractice		S.W. Mangement Co.	100.00%	1,609	1,609	25
26	V	27	Mgmt. Allocation of Benefits		S.W. Mangement Co.	100.00%	20,490	20,490	26
27	V	30	Depreciation		S.W. Mangement Co.	100.00%	5,452	5,452	27
28	V	32	Interest		S.W. Mangement Co.	100.00%	2,007	2,007	28
29	V	33	Real Estate Taxes		S.W. Mangement Co.	100.00%	4,924	4,924	29
30	V	35	Rent - Equipment & Vehicles		S.W. Mangement Co.	100.00%	1,605	1,605	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,500			$ 197,587	$ * 125,087	39

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 16,907	S & E Medical Supply Co.	100.00%	$ 15,345	$ (1,562)	15
16	V	3	Housekeeping	6,647	S & E Medical Supply Co.	100.00%	6,647		16
17	V	10	Medical Supplies	5,951	S & E Medical Supply Co.	100.00%	4,777	(1,174)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 29,505			$ 26,769	$ * (2,736)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Sheldon Wolfe	President	Administrative	42.50	See Schedule 7A	4	9.00	Salary	$ 67,094	L17, C7	1
2	Rosemary Betz	Adm. Consultant	Administrative	10.00	See Schedule 7B	8	13.79	Facility Fees	24,000	L17, C3	2
3	Moshe Herman	CFO	Administrative	5.00	See Schedule 7C	5.7	13.00	Salary	21,142	L21, C7	3
4											4
5											5
6			Note: All individuals work in excess of 40 hours per week								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 112,236		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: S.W. Management Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	570,112	10	$ (257)	$	75,190	$ (34)	1
2	3	Housekeeping	Bed Days Available	570,112	10	2,912		75,190	384	2
3	5	Heat and Other Utilities	Bed Days Available	570,112	10	20,748		75,190	2,736	3
4	6	Maintenance	Bed Days Available	570,112	10	6,462		75,190	852	4
5	19	Professional Services	Bed Days Available	570,112	10	29,160		75,190	3,846	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	570,112	10	640		75,190	84	6
7	21	Clerical & General Office Exp	Bed Days Available	570,112	10	652,396	606,507	75,190	86,042	7
8	24	Travel and Seminar	Bed Days Available	570,112	10	384		75,190	51	8
9	25	Other Admin. Staff Transport	Bed Days Available	570,112	10	3,378		75,190	445	9
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	570,112	10	12,203		75,190	1,609	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	570,112	10	155,361		75,190	20,490	11
12	32	Interest	Bed Days Available	570,112	10	15,217		75,190	2,007	12
13	33	Real Estate Taxes	Bed Days Available	570,112	10	37,335		75,190	4,924	13
14	35	Rent - Equipment & Vehicles	Bed Days Available	570,112	10	12,167		75,190	1,605	14
15										15
16	17	Administrative	Avg. Hours Worked	44	10	738,036	738,036	4	67,094	16
17	21	Clerical & General Office Exp	Avg. Hours Worked	40	7	60,000	60,000	0	0	17
18										18
19	30	Depreciation	Direct Cost						5,452	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,746,142	$ 1,404,543		$ 197,587	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: S & E Medical Supply Co.
Street Address: 3100 Commercial Avenue
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 982-9300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 15,345	1
2	3	Housekeeping	Direct Cost						6,647	2
3	10	Medical Supplies	Direct Cost						4,777	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 26,769	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	MB Financial Bank		X	Mortgage	$25,886.40	8/20/03	$	$ 3,958,471	8/20/08	0.0525	$ 249,492	1
2			X	N/P - Auto	$741.00	9/20/02	44,459	16,302	9/20/07	0.0600	185	2
3												3
4												4
5												5
	Working Capital											
6	Member Loans	X		Line of credit	Varies	12/15/02	1,000,000	800,000	12/20/06	0.0525	47,398	6
7	Member Loans	X		Working capital		11/15/02	406,189	406,189	Demand	0.0600	19,469	7
8												8
9	TOTAL Facility Related				$26,627.40		$ 1,450,648	$ 5,180,962			$ 316,544	9
	B. Non-Facility Related*											
10								Interest income offset			(2,812)	10
11								SW Mgmt allocation - Mortgage			2,008	11
12								Amortization of mortgage costs			10,995	12
13								Non-related interest			(66,867)	13
14	TOTAL Non-Facility Related						$	$			$ (56,676)	14
15	TOTALS (line 9+line14)						$ 1,450,648	$ 5,180,962			$ 259,868	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Tower Hill Healthcare Center **#** 0045930 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		$ 100,000	1
	Management Co. allocation	4,924	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2004	$ 93,526	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,550)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 100,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 1,819	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (5,339)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 94,930	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002	106,693	10
2003	96,996	11
2004	93,526	12

Accrual is consistent with prior year

SW Management allocation $4924

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tower Hill Healthcare Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0045930

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE 847-982-2300 FAX #: 847-982-2304

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-34-228-012	Long-term care property	$ 93,526.00	$ 93,526.00
2.	10-28-412-049-0000	SW Management allocation	$ 38,709.00	$ 4,924.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 132,235.00	$ 98,450.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider #: 0045930
12/31/2005

Schedule 10A

Allocation of Real Estate Tax Bill
S.W. Management Co.
Page 10, Line 2

Facility Name/ Real Estate Tax #	Basis of Allocation	Available Patient Days	% Allocated	Amount Allocated
10-28-412-049-0000				$ 38,709
% Applicable to Long Term Care:	Home Office/Management Fee			96.45%
				$ 37,335
Cahokia Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
Caseyville Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
Franklin Grove Nursing Center	Available Patient Days	44,165	7.75%	2,892
Hillside Manor Healthcare and Rehab	Available Patient Days	44,512	7.81%	2,915
Kenwood Healthcare Center	Available Patient Days	116,070	20.36%	7,601
Oregon Healthcare Center	Available Patient Days	37,960	6.66%	2,486
Shabbona Healthcare Center	Available Patient Days	33,215	5.83%	2,175
St. Elizabeth Healthcare Center	Available Patient Days	54,750	9.60%	3,585
Tower Hill Healthcare Center	Available Patient Days	75,190	13.19%	4,924
Virgil Calvert Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
		570,112	100.00%	$ 37,335

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,038 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization [X] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2000	$ 150,000	1
2					2
3	TOTALS			$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	206		2002		$ 4,259,594	$	39	$ 109,220	$ 109,220	$ 1,191,343	4
5											5
6	Mgmt Co		1995		57,085		39	1,631	1,631	17,378	6
7											7
8											8
	Improvement Type**										
9	Nursing Stations			2002	10,000		5	2,000	2,000	6,500	9
10	Carpet			2002	3,239		7	463	463	1,427	10
11	Time Recorder			2002	6,505		5	1,301	1,301	4,662	11
12	Fire Alarm System			2003	2,072		7	296	296	839	12
13	Recooling Tower Pump			2003	2,600		5	520	520	1,343	13
14	Hot Water Heater			2004	38,024	1,383	20	1,901	518	2,852	14
15	Alarm System			2004	24,807	902	20	1,240	338	1,860	15
16	Boiler			2005	19,350	674	20	484	(190)	484	16
17	Water softener valves & filter medi			2005	9,955	347	20	249	(98)	249	17
18	Hardware for 8 doors			2005	5,177	165	20	130	(35)	130	18
19	Wire glass in frames			2005	1,194	38	20	30	(8)	30	19
20	Door alarm system			2005	2,733	87	20	68	(19)	68	20
21	Resurface parking lo			2005	25,256	1,263	20	631	(632)	631	21
22	Elevator door edges			2005	2,400	40	20	60	20	60	22
23	Elevator pump			2005	1,450	2	20	36	34	36	23
24											24
25											25
26											26
27											27
28											28
29											29
30	Allocation of SW Management - Leasehold improvement			1995	6,090		20	305	305	3,674	30
31	Allocation of SW Management - Leasehold improvement			1996	1,064		20	53	53	509	31
32	Allocation of SW Management - Leasehold improvement			1997	1,532		20	77	77	840	32
33	Allocation of SW Management - Leasehold improvement			1998	1,054		20	53	53	409	33
34	Allocation of SW Management - Leasehold improvement			1999	2,928		20	146	146	891	34
35	Allocation of SW Management - Leasehold improvement			2005	6,058		20	151	151	151	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,490,167	$ 4,901		$ 121,045	$ 116,144	$ 1,236,366	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 49,549	$ 8,412	$ 8,729	$ 317	10	$ 23,060	71
72	Current Year Purchases	51,043	10,720	2,551	(8,169)	10	2,551	72
73	Fully Depreciated Assets	618,000					618,000	73
74	Allocation from Management Co.	15,409		1,506	1,506	10	14,065	74
75	TOTALS	$ 734,001	$ 19,132	$ 12,786	$ (6,346)		$ 657,676	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	2002 Volvo	2002	$ 39,234	$ 1,775	$ 7,847	$ 6,072	5	$ 30,211	76
77										77
78										78
79	Allocation from Mgmt. Co.	2004 Cadillac	2004	7,644		1,529	1,529	5	2,293	79
80	TOTALS			$ 46,878	$ 1,775	$ 9,376	$ 7,601		$ 32,504	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,421,046	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,808	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,207	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 117,399	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,926,546	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column (

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 14,640 Description: Copiers - $14,640
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20	SW Management allocation			1,605	20
21	TOTAL		$	$ 1,605	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Cente # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	12,828	$ 218,090	$	12,828	$ 218,090	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,963	77,112		2,963	77,112	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		13,168	221,221		13,168	221,221	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				183,800		183,800	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	28,959	$ 516,423	$ 183,800	28,959	$ 700,223	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center **#** 0045930 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$ 1,000	1
2	Cash-Patient Deposits	19,028	19,028	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,920,798	1,920,798	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,943	38,943	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	26,831	26,831	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,006,600	$ 2,006,600	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		4,290,740	14
15	Leasehold Improvements, at Historical Cost	141,346	199,427	15
16	Equipment, at Historical Cost	167,294	780,879	16
17	Accumulated Depreciation (book methods)	(98,071)	(1,926,546)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Schedule 17A	4,853	30,485	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 215,422	$ 3,524,985	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,222,022	$ 5,531,585	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 229,858	$ 229,858	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,992	22,992	28
29	Short-Term Notes Payable	1,206,189	1,206,189	29
30	Accrued Salaries Payable	195,674	195,674	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,634	22,634	31
32	Accrued Real Estate Taxes(Sch.IX-B)	100,000	100,000	32
33	Accrued Interest Payable	4,000	4,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	280,368	158,040	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,061,715	$ 1,939,387	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,302	16,302	39
40	Mortgage Payable		3,958,471	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 16,302	$ 3,974,773	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,078,018	$ 5,914,160	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 144,004	$ (382,575)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,222,022	$ 5,531,585	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Tower Hill Healthcare Center
Provider #:0045930
12/31/2005

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from prior owners	20,382	20,382
Employee loans	2,350	2,350
Employee payroll Advance	1,255	1,255
Prepaid Expenses	2,745	2,745
Due to Public Aid	99	99
Total Line 9 - Other Current Assets (specify):	**26,831**	**26,831**

Other Long Term Assets (specify):	Operating	After Consolidation
Short Term Loan Exchange	4,853	4,853
Loan Costs	0	51,107
A/A Loan costs	0	(25,475)
Total Line 23 - Other Long Term Assets (specify):	**4,853**	**30,485**

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	1,496	1,496
Due to state	12,494	12,494
Credit union	275	275
Union dues	2,812	2,812
Accrued Expenses	115,936	115,936
Accrued Management fees	2,000	2,000
Due / from Kane St. Assoc	145,355	0
Due to Partners	.	23,027
Total Line 36 - Other Current Liabilities (specify):	**280,368**	**158,040**

See Accountants' Compilation Repor

Facility Name & ID Number Tower Hill Healthcare Center **#** 0045930 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (607,947)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (607,947)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	751,951	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 751,951	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 144,004	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 6,691,286	1
2	Discounts and Allowances for all Level		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,691,286	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,871	6
7	Oxygen	22,865	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 310,736	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	2,812	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,812	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	256	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 256	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,005,090	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,264,816	31
32	Health Care	2,855,235	32
33	General Administratior	1,108,338	33
	B. Capital Expense		
34	Ownership	615,688	34
	C. Ancillary Expense		
35	Special Cost Centers	296,277	35
36	Provider Participation Fee	112,785	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,253,139	40
41	**Income before Income Taxes (line 30 minus line 40)****	751,951	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 751,951	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,072	2,080	$ 62,771	$ 30.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,889	30,660	858,329	28.00	3
4	Licensed Practical Nurses	7,962	8,206	206,102	25.12	4
5	CNAs & Orderlies	72,468	77,105	924,861	11.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,178	10,734	130,372	12.15	10
11	Social Service Workers	2,080	2,080	34,227	16.46	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	42,808	20.58	13
14	Head Cook	6,311	7,059	73,833	10.46	14
15	Cook Helpers/Assistants	18,409	19,849	152,222	7.67	15
16	Dishwashers					16
17	Maintenance Worker	4,060	4,444	62,279	14.01	17
18	Housekeepers	16,524	17,781	143,291	8.06	18
19	Laundry	10,356	11,496	92,460	8.04	19
20	Administrator	2,080	2,080	115,426	55.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,738	18,502	303,348	16.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,207	214,156	$ 3,202,329 *	$ 14.95	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	90	$ 8,605	L1, C3	35
36	Medical Director	270	26,510	L9, C3	36
37	Medical Records Consultant	80	3,578	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	35	4,918	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan	84	10,749	L10A, C3	41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	559	$ 54,360		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number: Tower Hill Healthcare Cente | # 0045930 | Report Period Beginning: 01/01/2005 | Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Amster	Administrator	0	$ 115,426
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 115,426

B. Administrative - Other

Description	Amount
Rose Betz - Management Fees	$ 24,000
SW Management - Home Office	72,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 96,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 15,236
Ashman & Stein	Legal	6,609
Stone, Pogrund & Korey	Legal	447
Foley & Lardner LLP	Legal	135
Allen A Lefkovitz & Associates	Legal	1,819
American Express TBS	Accounting	14,669
Personal Planners Inc.	Unemployment Consultant	1,980
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 40,895

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,997
Unemployment Compensation Insurance	70,929
FICA Taxes	241,993
Employee Health Insurance	31,279
Employee Meals	4,671
Illinois Municipal Retirement Fund (IMRF)*	
Misc employee benefits	13,737
Uniforms	9,135
Retirement Plan	16,205
TOTAL (agree to Schedule V, line 22, col.8)	$ 448,946

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 97)	1,354
Inspections	145
Dues and Subscriptions	301
IL Council on Long Term Care	5,284
Licenses	470
SW Management Allocation	84
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,628

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,540
SW Management Allocation	51
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,591

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Tower Hill Healthcare Center
Provider #: 0045930
12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	40,895
Out-of-period legal expenses	(573)
Reclass to Real Estate Taxes	(1,819)
Allocated From Kane Street Associates	
Accounting	1,244
Allocated From SW Management:	
Accounting	1,858
Legal	1,988
Total (agree to Schedule V, line 19, column 8)	43,593

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center # 0045930 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5			N/A										
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tower Hill Healthcare Center **#** 0045930 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **IL Council on Long Term Care - $5,284**

(3) Did the nursing home make political contributions or payments to a politic action organization? **Yes** If YES, have these cost been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perioc **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **26,340** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreemen ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **112,785**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **4,671** Has any meal income been offset agains related costs? **N/A** Indicate the amount $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **N/A**
d. Have vehicle usage logs been maintained **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjust out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? **N/A** If no, please explain **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT **12:13 PM** **5/16/2006**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-107,579	equal to	-107,579	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	259,868	equal to	259,868	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	94,930	equal to	94,930	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	143,207	equal to	143,207	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	16,245	equal to	16,245	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	527,172	equal to	527,172	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	183,800	equal to	183,800	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,264,816	equal to	1,264,816	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,855,235	equal to	2,855,235	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,108,338	equal to	1,108,338	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	615,688	equal to	615,688	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	296,277	equal to	296,277	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	112,785	equal to	112,785	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,052,063	equal to	2,052,063	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	130,372	equal to	130,372	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	34,227	equal to	34,227	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	268,863	equal to	268,863	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	62,279	equal to	62,279	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	143,291	equal to	143,291	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	92,460	equal to	92,460	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	115,426	equal to	115,426	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	303,348	equal to	303,348	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,202,329	equal to	3,202,329	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,605	< or = to	8,605	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	26,510	< or = to	26,510	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	8,496	< or = to	8,496	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	115,426	equal to	115,426	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	96,500	equal to	96,500	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	40,895	equal to	40,895	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	448,946	equal to	448,946	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,628	equal to	9,628	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,591	equal to	4,591	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	112,785	equal to	112,785	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	4,671	< or = to	4,671	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	4,671	equal to	4,671	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,357	equal to	6,357	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	74,069	equal to	74,069	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	5,180,962	equal to	5,180,962	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	100,000	equal to	100,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	150,000	equal to	150,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,490,167	equal to	4,490,167	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	780,879	equal to	780,879	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,926,546	equal to	1,926,546	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	144,004	equal to	144,004	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	751,951	equal to	751,951	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,222,022	equal to	2,222,022	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	268,863	19,528	8,605	296,996	0	296,996	0	296,996
2. Food Purchase	0	272,332	0	272,332	0	272,332	-6,267	266,065
3. Housekeeping	143,291	90,411	0	233,702	0	233,702	384	234,086
4. Laundry	92,460	22,604	0	115,064	0	115,064	0	115,064
5. Heat and Other Utilities	0	0	155,192	155,192	0	155,192	2,736	157,928
6. Maintenance	62,279	114,874	14,377	191,530	0	191,530	852	192,382
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	566,893	519,749	178,174	1,264,816	0	1,264,816	-2,295	1,262,521
9. Medical Director	0	0	26,510	26,510	0	26,510	0	26,510
10. Nursing & Medical Records	2,052,063	62,551	8,496	2,123,110	0	2,123,110	-1,174	2,121,936
10a. Therapy	0	0	527,172	527,172	0	527,172	0	527,172
11. Activities	130,372	13,844	0	144,216	0	144,216	0	144,216
12. Social Services	34,227	0	0	34,227	0	34,227	0	34,227
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,216,662	76,395	562,178	2,855,235	0	2,855,235	-1,174	2,854,061
17. Administrative	115,426	0	96,500	211,926	0	211,926	-5,406	206,520
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	40,895	40,895	0	40,895	2,698	43,593
20. Fees, Subscriptions & Promotion	0	0	10,167	10,167	0	10,167	-539	9,628
21. Clerical & General Office	303,348	0	62,948	366,296	0	366,296	85,786	452,082
22. Employee Benefits & Payroll	0	0	444,275	444,275	0	444,275	4,671	448,946
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	4,540	4,540	0	4,540	51	4,591
25. Other Admin. Staff Trans	0	0	10,871	10,871	0	10,871	445	11,316
26. Insurance-Prop.Liab.Malpractice	0	0	19,368	19,368	0	19,368	1,609	20,977
27. Other (specify)*	0	0	0	0	0	0	20,490	20,490
28. Total General Adminis	418,774	0	689,564	1,108,338	0	1,108,338	109,805	1,218,143
29. Total General Administrative	3,202,329	596,144	1,429,916	5,228,389	0	5,228,389	106,336	5,334,725
30. Depreciation	0	0	25,808	25,808	0	25,808	117,399	143,207
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	67,053	67,053	0	67,053	192,815	259,868
33. Real Estate	0	0	88,187	88,187	0	88,187	6,743	94,930
34. Rent - Facility & Grounds	0	0	420,000	420,000	0	420,000	-420,000	0
35. Rent - Equipment & Vehicles	0	0	14,640	14,640	0	14,640	1,605	16,245
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	615,688	615,688	0	615,688	-101,438	514,250
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	183,800	0	183,800	0	183,800	0	183,800
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	112,785	112,785	0	112,785	0	112,785
43. Other (specify):*	0	0	112,477	112,477	0	112,477	-112,477	0
44. Total Special Cost Ce	0	183,800	225,262	409,062	0	409,062	-112,477	296,585
45. Grand Total	3,202,329	779,944	2,270,866	6,253,139	0	6,253,139	-107,579	6,145,560

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,000	1,000
2. Cash - Patient Deposits	19,028	19,028
3. Accounts & Notes Recievable	1,920,798	1,920,798
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	38,943	38,943
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	26,831	26,831
10. Total current assets	2,006,600	2,006,600
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	150,000
14. Buildings, at Historical Cost	0	4,290,740
15. Leasehold Improvements, Historical Cost	141,346	199,427
16. Equipment, at Historical Cost	167,294	780,879
17. Accumulated Depreciation (book methods)	-98,071	-1,926,546
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	4,853	30,485
24. Total Long-Term Assets	215,422	3,524,985
25. Total Assets	2,222,022	5,531,585
CURRENT LIABILITIES		
26. Accounts Payable	229,858	229,858
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	22,992	22,992
29. Short-Term Notes Payable	1,206,189	1,206,189
30. Accrued Salaries Payable	195,674	195,674
31. Accrued Taxes Payable	22,634	22,634
32. Accrued Real Estate Taxes	100,000	100,000
33. Accrued Interest Payable	4,000	4,000
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	280,368	158,040
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,061,715	1,939,387
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	3,958,471
40.Mortgage Payable	16,302	16,302
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	16,302	3,974,773
46.Total Liabilities	2,078,017	5,914,160
47.Total Equity	144,005	-382,575
48.Total Liabilities and Equity	2,222,022	5,531,585

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,691,286
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	6,691,286
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	287,871
7. Oxygen	22,865
Subtotal - Anciliary Revenue	310,736
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	2,812
Subtotal - Non-Operating Revenue	2,812
27. Other Revenue (specify):	256
28. Other Revenue (specify):	0
Subtotal - Other Revenue	256
30. Total Revenue	7,005,090
31. General Services	1,264,816
32. Health Care	2,855,235
33. General Administration	1,108,338
34. Ownership	615,688
35. Special Cost Centers	296,277
35. Provider Participation Fee	112,785
37. Other	0
40. Total Expenses	6,253,139
41. Income Before Income Taxes	751,951
42. Income Taxes	0
43. Net Income or Loss for the Year	751,951